JAHMALE MEDICAL SOLUTIONS
Your Health Matters
A NASSCORP INITIATIVE

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# Imaging Request Form

**MRI, CT, Mammogram, EKG, X-ray, Ultrasound**
**Scheduling Tel:** +231 88 160 3000 / +231 77 660 3000
**Email:** imagingservices@jahmalemedical.org
**Reg. No. 052115698**

| **Ref. Number** | **Barcode** |
|---|---|
| | |

## Patient Details:

Last Name: .....

First Name: .....

Date of Birth: DD / MM / YYYY Age:_____ Gender: M ☐ F ☐

ID Number: .....

Address: .....

.....

Mobile Number: .....

Email: .....

## Payment Details: Priority: _____

By Patient ☐ Monthly Payment ☐

## Person(s) Responsible For Payment:

Patient's Insurance Company: .....

Membership Number: .....

Pre-Authorization Number (If Known): .....

**Please note:** *Uninsured patients and patients without pre-authorization are required to pay on the day of their appointment.*

## Referral Information:

☐ **MRI** ☐ **CT** ☐ **X-RAY** ☐ **ULTRASOUND** ☐ **MAMMOGRAM** ☐ **EKG**

**Area to be imaged:** .....

Creatinine level: ..... Date of Test: .....

## Relevant Medical History:

*Details (Including any surgery and current medication)*

.....

.....

***Please include copies of any recent X-ray or scan reports***

## Safety Check:

| | | | |
|---|---|---|---|
| Could the patient be pregnant? | Yes ☐ | No ☐ | |
| Is the patient breast feeding? | Yes ☐ | No ☐ | |
| Is the patient a high infection risk? | Yes ☐ | No ☐ | |
| If yes, please specify ..... | | | |
| Is the patient diabetic | Yes ☐ | No ☐ | |
| Is the diabetes controlled by: | Diet ☐ | Insulin ☐ | Tablet ☐ |
| Is the patient on Metformin? | Yes ☐ | No ☐ | |
| Does the patient have any allergies | Yes ☐ | No ☐ | |
| If yes, please specify: ..... | | | |

**Patient arrival:** Stretcher ☐ Wheelchair ☐ Walking ☐

**Weight of Patient:** ..... **Height of Patient**: .....

## To be completed for all MRI examinations

**MRI Contraindications** – *does the patient have*:

| | | |
|---|---|---|
| A pacemaker? | Yes ☐ | No ☐ |
| A cerebral aneurysm clip? | Yes ☐ | No ☐ |
| Cochlear implants? | Yes ☐ | No ☐ |
| Neurostimulators? | Yes ☐ | No ☐ |
| Programmable hydrocephalus shunt? | Yes ☐ | No ☐ |
| Metallic foreign body in eye? | Yes ☐ | No ☐ |
| Other metallic implants? | Yes ☐ | No ☐ |

## Referring Clinician's Details (To be signed by the Referring Clinician):

Name: .....

Signature: ..... Date: .....

Address: .....

Tel: ..... Fax: .....

Email: .....

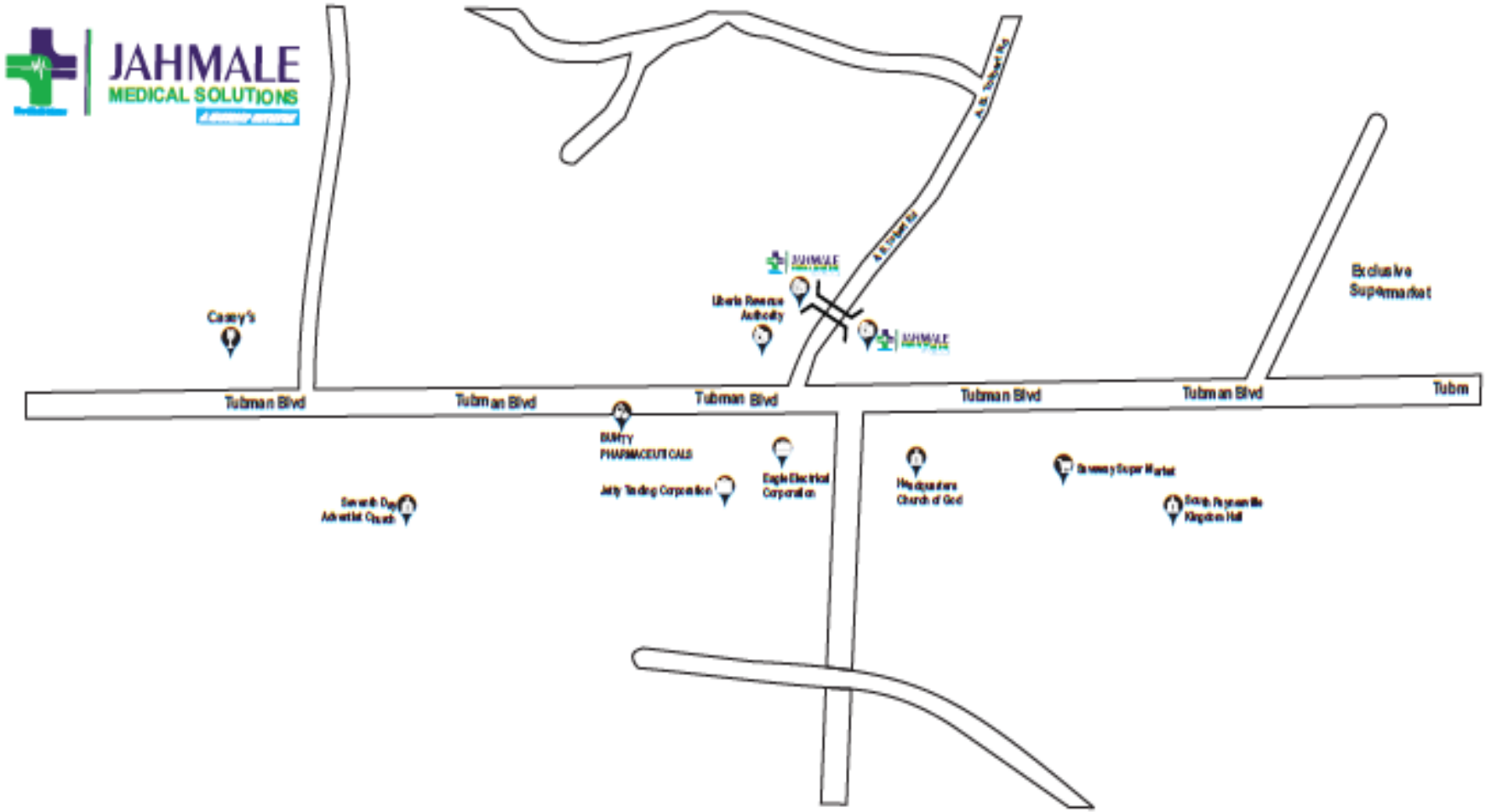
*I, certify that the above information is correct and give specific consent for the test(s) to be done. I have received pre-test counseling. I, undertake to pay outstanding monies not covered by my medical insurance.*

**Patient's Signature**: .....

| **Amount Billed:** | **Amount Paid:** | **Balance:** |
|---|---|---|
| | | |

**Received By:**

**Form Filled By:** **Reg. By:**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